CHANGE FORM

Office Use Only

Approved By:
Date of Approval:
ID #:

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

MEDICAL MARIJUANA PROGRAM - PATIENT INFORMATION CHANGE REQUEST

Instructions: Please provide your name, as it appears on your registration card, your date of birth and your registration number below. Check the box in the section that you would like to change and enter the new information; or indicate withdrawal from the program. Sign, date and mail the completed form to the address listed above.

Patient Name (First, M.I., Last) as it appears on your registration card:	**Date of Birth:**	**Registration Number**

Provide changes to your registration information below. Check the box in the section that you wish to change.

A. PATIENT INFORMATION ☐ **Change Name or Address ($10.00)**

Patient Name (First, M.I., Last)	Telephone Number: ( )
Mailing Address:	Email Address:
City, State, Zip Code:	

B. PRIMARY CAREGIVER #1 ☐ **Change Name or Address ($10.00)** ☐ **Add New ($0)** ☐ **Drop ($0)**

Caregiver Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

C. PRIMARY CAREGIVER #2 ☐ **Change Name or Address ($10.00)** ☐ **Add New ($0)** ☐ **Drop ($0)**

Caregiver Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

D. WITHDRAWAL FROM MARIJUANA PROGRAM ☐ **Withdraw from Program ($0)**

CHANGE IN DEBILITATING MEDICAL CONDITION

I no longer have the debilitating medical condition that qualified me for inclusion in the Rhode Island Medical Marijuana Program. I understand that my registration card and the registration cards of my primary caregiver(s) will become null and void as soon as the Department of Health receives this form. I agree to return my registry identification card to the Department of Health.

E. PATIENT'S ATTESTATION SIGNATURE AND DATE

I hereby certify that all of the information provided on this form is true and accurate to the best of my knowledge. I understand that if I change my name (e.g. marriage) or address; or either of my primary caregiver's names (e.g. marriage) or addresses, there is a ten-dollar (**$10.00**) (NON-REFUNDABLE) registry identification card fee **for EACH PERSON'S RECORD CHANGE** (that requires the printing of a NEW registry identification card). ***There is no fee to add a new caregiver or to drop a current caregiver, or to change telephone numbers or email addresses for patients or caregivers.***

Checks or money orders must be made payable to the "General Treasurer, State of Rhode Island". If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete the form; attest to; and sign this statement. I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use this "Patient Information Change Request Form"), within ten (10) days of any changes to the information provided.

Patient's Signature:	Date of Signature:
Proxy's Signature (if applicable):	Date of Signature:

This form is to be completed by the Patient or Proxy and is for CHANGES to registration information or WITHDRAWAL only. Revised 03/21/2006 AWP